Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: Toledo, OH, Outpatient Clinic

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 20

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **20** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	316	35
Transitional Housing Beds	344	30
Permanent Housing Beds	25	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Thirty-five bed program for homeless women will be re-opened this fall.
Long-term, permanent housing	Will continue to utilize referrals to FOCUS, NPI which have been successful in past.
Job Training	New project with Goodwill Industries this year. Continues to improve.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 33 Non-VA staff Participants: 70% Homeless/Formerly Homeless: 18%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.23	7%	2.39	3
2	Legal assistance	2.59	7%	2.61	4
3	Guardianship (financial)	2.63	7%	2.76	9
4	Help managing money	2.77	10%	2.71	7
5	Family counseling	2.84	0%	2.85	12
6	Drop-in center or day program	2.86	0%	2.77	10
7	Welfare payments	2.9	0%	2.97	16
8	Job training	2.94	10%	2.88	14
9	Long-term, permanent housing	3	17%	2.25	1
10	Education	3	7%	2.88	13
11	Discharge upgrade	3.17	3%	2.90	15
12	Glasses	3.19	0%	2.67	6
13	Women's health care	3.21	0%	3.09	21
14	Eye care	3.25	0%	2.65	5
15	Help with finding a job or getting employment	3.29	14%	3.00	17
16	Dental care	3.33	20%	2.34	2
17	Spiritual	3.34	0%	3.30	27
18	TB treatment	3.39	0%	3.45	33
19	Hepatitis C testing	3.44	0%	3.41	32
20	Help with transportation	3.47	3%	2.82	11
21	Detoxification from substances	3.5	10%	3.11	22
22	VA disability/pension	3.52	7%	3.33	29
23	SSI/SSD process	3.52	3%	3.02	19
24	AIDS/HIV testing/counseling	3.55	0%	3.38	30
25	Halfway house or transitional living facility	3.56	7%	2.76	8
26	Treatment for dual diagnosis	3.56	7%	3.01	18
27	Personal hygiene (shower, haircut, etc.)	3.59	3%	3.21	26
28	Emergency (immediate) shelter	3.59	17%	3.04	20
29	TB testing	3.64	0%	3.58	36
30	Clothing	3.72	0%	3.40	31
31	Treatment for substance abuse	3.81	14%	3.30	28
32	Help getting needed documents or identification	3.84	0%	3.16	23
33	Services for emotional or psychiatric problems	3.88	14%	3.20	25
34	Food	3.91	7%	3.56	35
35	Help with medication	4	0%	3.18	24
36	Medical services	4.29	7%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.12	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.63	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.61	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.59	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.69	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.5	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.45	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.33	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.21	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.07	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.54	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.11	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.08	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.56	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.78	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.24	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.21	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.29	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

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CHALENG 2004 Survey: VA Ann Arbor HCS, MI - 506, Flint, MI

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Point-in-time estimate of Veterans who are Chronically Homeless: 45

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **100** (point-in-time estimate of homeless veterans in service area) **X 47%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 45** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	254	130
Transitional Housing Beds	433	20
Permanent Housing Beds	46	372

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work with HUD Continuum of Care board and community housing coalition on the development of long-term housing for homeless veterans.
Services for emotional or psychiatric problems	Work with Continuum of Care board and coalition housing committees on the development/implementation of supportive services for homeless veterans with emotional or psychiatric problems.
Dental Care	Continue to work with HUD Continuum of Care board and community housing committees on the development of new resources in the community to provide dental services to homeless veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25 Non-VA staff Participants: 76%
Homeless/Formerly Homeless: 8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.87	39%	2.25	1
2	Child care	2.25	0%	2.39	3
3	Help with finding a job or getting employment	2.27	17%	3.00	17
4	Legal assistance	2.29	0%	2.61	4
5	Halfway house or transitional living facility	2.52	35%	2.76	8
6	Family counseling	2.52	0%	2.85	12
7	Help managing money	2.57	4%	2.71	7
8	Drop-in center or day program	2.59	4%	2.77	10
9	Dental care	2.59	4%	2.34	2
10	Detoxification from substances	2.63	0%	3.11	22
11	Education	2.64	0%	2.88	13
12	Job training	2.67	4%	2.88	14
13	Treatment for dual diagnosis	2.68	13%	3.01	18
14	Guardianship (financial)	2.73	0%	2.76	9
15	Treatment for substance abuse	2.74	13%	3.30	28
16	Emergency (immediate) shelter	2.82	30%	3.04	20
17	Help getting needed documents or identification	2.95	0%	3.16	23
18	Welfare payments	3	0%	2.97	16
19	Help with transportation	3	4%	2.82	11
20	Eye care	3.05	0%	2.65	5
21	Discharge upgrade	3.05	0%	2.90	15
22	Glasses	3.14	0%	2.67	6
23	SSI/SSD process	3.14	4%	3.02	19
24	Women's health care	3.22	4%	3.09	21
25	Personal hygiene (shower, haircut, etc.)	3.26	0%	3.21	26
26	Help with medication	3.26	0%	3.18	24
27	Services for emotional or psychiatric problems	3.38	0%	3.20	25
28	AIDS/HIV testing/counseling	3.4	4%	3.38	30
29	Clothing	3.48	0%	3.40	31
30	VA disability/pension	3.5	4%	3.33	29
31	Food	3.52	4%	3.56	35
32	Spiritual	3.55	0%	3.30	27
33	TB treatment	3.65	0%	3.45	33
34	Hepatitis C testing	3.82	0%	3.41	32
35	TB testing	4	0%	3.58	36
36	Medical services	4.22	4%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.7	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.43	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.82	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.22	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.86	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.57	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.62	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.9	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.42	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.65	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.63	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.78	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.21	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.79	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.41	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.61	1.84

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CHALENG 2004 Survey: VA Northern Indiana HCS (VAMC Fort Wayne - 610A4 and VAMC Marion - 610)

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 300

2. Point-in-time estimate of Veterans who are Chronically Homeless: 55

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **300** (point-in-time estimate of homeless veterans in service area) **X 24%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 77%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 55** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	220	75
Transitional Housing Beds	36	50
Permanent Housing Beds	0	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Encourage community agencies to apply for VA Grant and Per Diem Funds.
Long-term, permanent housing	Continue discussion and interaction with agencies on individual client situations for permanent housing.
Immediate shelter	No new emergency beds were added at the Fort Wayne Rescue Mission as planned. The Mission also excludes parolees from staying, further restricting available access for homeless veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 90%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.21	41%	2.25	1
2	Child care	2.22	0%	2.39	3
3	Halfway house or transitional living facility	2.26	29%	2.76	8
4	Discharge upgrade	2.28	0%	2.90	15
5	Legal assistance	2.33	0%	2.61	4
6	Welfare payments	2.37	0%	2.97	16
7	Drop-in center or day program	2.42	6%	2.77	10
8	Guardianship (financial)	2.42	0%	2.76	9
9	Emergency (immediate) shelter	2.47	24%	3.04	20
10	Treatment for dual diagnosis	2.47	12%	3.01	18
11	Help getting needed documents or identification	2.47	0%	3.16	23
12	Job training	2.53	6%	2.88	14
13	Help with transportation	2.53	0%	2.82	11
14	Eye care	2.58	0%	2.65	5
15	Glasses	2.58	0%	2.67	6
16	SSI/SSD process	2.58	12%	3.02	19
17	Detoxification from substances	2.6	0%	3.11	22
18	Help with finding a job or getting employment	2.61	6%	3.00	17
19	Help managing money	2.63	6%	2.71	7
20	Education	2.63	12%	2.88	13
21	Dental care	2.68	0%	2.34	2
22	Treatment for substance abuse	2.7	0%	3.30	28
23	Services for emotional or psychiatric problems	2.79	12%	3.20	25
24	Help with medication	2.79	12%	3.18	24
25	Family counseling	2.84	0%	2.85	12
26	Personal hygiene (shower, haircut, etc.)	2.95	0%	3.21	26
27	Women's health care	2.95	0%	3.09	21
28	VA disability/pension	2.95	6%	3.33	29
29	AIDS/HIV testing/counseling	3	0%	3.38	30
30	Hepatitis C testing	3	0%	3.41	32
31	Spiritual	3.05	12%	3.30	27
32	Medical services	3.11	0%	3.55	34
33	TB treatment	3.16	0%	3.45	33
34	TB testing	3.21	0%	3.58	36
35	Clothing	3.22	12%	3.40	31
36	Food	3.42	6%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.68	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.95	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.37	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.65	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.32	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.15	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.89	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.05	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.78	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.61	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.61	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.72	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.24	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.5	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.53	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.29	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.35	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.31	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.47	1.84

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CHALENG 2004 Survey: VAMC Battle Creek, MI - 515

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 750

2. Point-in-time estimate of Veterans who are Chronically Homeless: 125

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **750** (point-in-time estimate of homeless veterans in service area) **X 20%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 84%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 125** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	180
Transitional Housing Beds	90	100
Permanent Housing Beds	100	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue collaboration with Dwelling Place in Kent County for completion of permanent supported housing unit of 30 beds.
Dental Care	Continue coordination with Battle Creek VAMC dentist for treatment.
Immediate shelter	Support HUD Continuum of Care and expansion of local shelter.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 47 Non-VA staff Participants: 78%
Homeless/Formerly Homeless: 9%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.15	0%	2.39	3
2	Dental care	2.24	16%	2.34	2
3	Legal assistance	2.47	5%	2.61	4
4	Long-term, permanent housing	2.51	41%	2.25	1
5	Treatment for dual diagnosis	2.54	5%	3.01	18
6	Discharge upgrade	2.57	3%	2.90	15
7	Detoxification from substances	2.62	11%	3.11	22
8	Eye care	2.65	3%	2.65	5
9	Help managing money	2.65	5%	2.71	7
10	Family counseling	2.68	0%	2.85	12
11	Drop-in center or day program	2.68	8%	2.77	10
12	Women's health care	2.7	3%	3.09	21
13	Education	2.7	8%	2.88	13
14	Guardianship (financial)	2.72	0%	2.76	9
15	Glasses	2.78	5%	2.67	6
16	Welfare payments	2.8	0%	2.97	16
17	Job training	2.85	16%	2.88	14
18	Halfway house or transitional living facility	2.87	16%	2.76	8
19	Treatment for substance abuse	2.9	8%	3.30	28
20	Services for emotional or psychiatric problems	2.9	5%	3.20	25
21	SSI/SSD process	2.92	3%	3.02	19
22	Help with medication	2.95	3%	3.18	24
23	AIDS/HIV testing/counseling	2.95	0%	3.38	30
24	TB testing	3.03	0%	3.58	36
25	Hepatitis C testing	3.03	0%	3.41	32
26	Help with finding a job or getting employment	3.05	14%	3.00	17
27	TB treatment	3.06	0%	3.45	33
28	Help with transportation	3.14	0%	2.82	11
29	Personal hygiene (shower, haircut, etc.)	3.19	0%	3.21	26
30	Spiritual	3.19	3%	3.30	27
31	Medical services	3.21	8%	3.55	34
32	VA disability/pension	3.24	8%	3.33	29
33	Emergency (immediate) shelter	3.26	5%	3.04	20
34	Help getting needed documents or identification	3.3	0%	3.16	23
35	Clothing	3.36	0%	3.40	31
36	Food	3.69	3%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.34	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.15	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.56	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.65	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.63	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.68	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.46	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.28	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.37	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.18	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.68	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.18	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.91	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.88	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.29	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.97	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.18	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.03	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.97	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Danville, IL - 550

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 995

2. Point-in-time estimate of Veterans who are Chronically Homeless: 403

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **995** (point-in-time estimate of homeless veterans in service area) **X 64%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 64%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 403** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	60	90
Permanent Housing Beds	60	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We are awaiting the construction of a 10-bed housing unit located in Peoria, Illinois, to provide permanent housing for homeless veterans in FY 2005. We are continuing efforts with area homeless coalitions to identify and secure Section 8 vouchers and other permanent housing resources for homeless veterans.
Transitional living facility	Will fully implement VA Grant and Per Diem awards to Phoenix House and Home Sweet Home providing 20 new transitional beds and supportive services for our homeless veterans.
Dental Care	Will continue to implement VHA Directive 2002-080 to provide dental care for homeless veterans in need and eligible for services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 26 Non-VA staff Participants: 65% Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.96	29%	2.34	2
2	Long-term, permanent housing	2.5	29%	2.25	1
3	Glasses	2.52	0%	2.67	6
4	Legal assistance	2.52	8%	2.61	4
5	Eye care	2.57	0%	2.65	5
6	Halfway house or transitional living facility	2.6	21%	2.76	8
7	Help managing money	2.65	8%	2.71	7
8	Help with transportation	2.71	13%	2.82	11
9	Guardianship (financial)	2.82	0%	2.76	9
10	Child care	2.82	4%	2.39	3
11	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
12	Education	3	4%	2.88	13
13	SSI/SSD process	3.04	4%	3.02	19
14	Job training	3.08	8%	2.88	14
15	Women's health care	3.09	0%	3.09	21
16	Drop-in center or day program	3.09	4%	2.77	10
17	Welfare payments	3.09	0%	2.97	16
18	Emergency (immediate) shelter	3.12	17%	3.04	20
19	Family counseling	3.13	4%	2.85	12
20	Detoxification from substances	3.21	0%	3.11	22
21	Help with finding a job or getting employment	3.21	4%	3.00	17
22	Help with medication	3.22	0%	3.18	24
23	Treatment for dual diagnosis	3.27	8%	3.01	18
24	Services for emotional or psychiatric problems	3.3	4%	3.20	25
25	Discharge upgrade	3.37	0%	2.90	15
26	Treatment for substance abuse	3.39	8%	3.30	28
27	Help getting needed documents or identification	3.41	4%	3.16	23
28	VA disability/pension	3.43	0%	3.33	29
29	Clothing	3.46	4%	3.40	31
30	AIDS/HIV testing/counseling	3.48	0%	3.38	30
31	Spiritual	3.48	4%	3.30	27
32	TB treatment	3.5	0%	3.45	33
33	Food	3.54	8%	3.56	35
34	Medical services	3.54	4%	3.55	34
35	TB testing	3.61	0%	3.58	36
36	Hepatitis C testing	3.74	0%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.54	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.28	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.96	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.32	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.96	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.12	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.8	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.84	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.76	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.91	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.14	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.48	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.3	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.42	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.47	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.1	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.26	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.26	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.74	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Detroit, MI - 553

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2150

2. Point-in-time estimate of Veterans who are Chronically Homeless: 131

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2150** (point-in-time estimate of homeless veterans in service area) **X 8%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 78%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 131** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	550	20
Transitional Housing Beds	260	100
Permanent Housing Beds	50	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We are anticipating the approval of the Detroit Veterans Center as a VA Grant and Per Diem provider which we hope will result in an increase in the number of our veterans who complete the transitional program and have the resources to obtain and maintain permanent housing. Will continue to attempt to secure Section 8 vouchers. Will also continue to work with other providers in writing for grants to provide additional permanent housing.
Dental Care	Will continue to research and access opportunities in the community for free and/or reduced cost dental care. If the DVC becomes a GPD provider, we will try to work with our dental service to provide care.
Welfare Payments	We have a VBC who provides dedicated service to homeless veterans in our community. He is available on site once per week and at other sites in the community on a regular basis. We have a Social Security rep on site on a weekly basis. Patients who may be eligible for other funds are referred for same. We will continue to assess our clients as to financial needs and refer to appropriate resources.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 35 Non-VA staff Participants: 80%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.32	14%	2.34	2
2	Welfare payments	2.43	0%	2.97	16
3	Child care	2.52	0%	2.39	3
4	Eye care	2.61	4%	2.65	5
5	Guardianship (financial)	2.71	11%	2.76	9
6	Drop-in center or day program	2.74	0%	2.77	10
7	Help with transportation	2.74	0%	2.82	11
8	Glasses	2.75	0%	2.67	6
9	Education	2.81	0%	2.88	13
10	Legal assistance	2.81	4%	2.61	4
11	Help managing money	2.83	0%	2.71	7
12	Long-term, permanent housing	2.88	18%	2.25	1
13	Family counseling	2.93	4%	2.85	12
14	SSI/SSD process	2.93	14%	3.02	19
15	Job training	2.93	4%	2.88	14
16	Services for emotional or psychiatric problems	2.96	7%	3.20	25
17	Treatment for dual diagnosis	3	4%	3.01	18
18	TB testing	3	0%	3.58	36
19	Hepatitis C testing	3	0%	3.41	32
20	AIDS/HIV testing/counseling	3.07	0%	3.38	30
21	TB treatment	3.08	0%	3.45	33
22	Help with medication	3.11	0%	3.18	24
23	Discharge upgrade	3.12	4%	2.90	15
24	Help with finding a job or getting employment	3.17	14%	3.00	17
25	Personal hygiene (shower, haircut, etc.)	3.21	11%	3.21	26
26	Women's health care	3.22	0%	3.09	21
27	Halfway house or transitional living facility	3.23	29%	2.76	8
28	Spiritual	3.24	11%	3.30	27
29	Detoxification from substances	3.29	7%	3.11	22
30	VA disability/pension	3.29	11%	3.33	29
31	Treatment for substance abuse	3.3	11%	3.30	28
32	Medical services	3.32	0%	3.55	34
33	Help getting needed documents or identification	3.36	0%	3.16	23
34	Emergency (immediate) shelter	3.37	7%	3.04	20
35	Food	3.47	14%	3.56	35
36	Clothing	3.5	7%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.81	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.31	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.03	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.32	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.97	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.26	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.81	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.63	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.35	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.84	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.77	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.13	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.77	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.77	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.9	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.63	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.67	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.5	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Indianapolis - 583

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1200

2. Point-in-time estimate of Veterans who are Chronically Homeless: 270

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1200** (point-in-time estimate of homeless veterans in service area) **X 23%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 96%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 270** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	716	484
Transitional Housing Beds	1180	30
Permanent Housing Beds	500	230

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Partners in Housing Development Corporation will implement the Colonial Park Apartment Project to include 106 permanent housing beds for homeless/disabled persons. Thirty additional beds for homeless/disabled persons at the Salvation Army Burton House. Will apply for the homeless providers VA Grant and Per Diem special needs project that has a permanent housing component.
Job Training	Training and implementation of supportive employment within our vocational rehabilitation program. Offer assistance to Goodwill Industries and HVAF in receiving the HVRP grant. Expand NISH opportunity through Goodwill.
Dental Care	Increase referrals to Gennesaret Clinic. Increase utilization of VA dental services through VA Directive 2002-080. Renew Gennesaret Dental Clinic grant from DAV.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 29 Non-VA staff Participants: 62% Homeless/Formerly Homeless: 14%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.27	4%	2.39	3
2	Legal assistance	2.31	0%	2.61	4
3	Detoxification from substances	2.33	28%	3.11	22
4	Guardianship (financial)	2.38	8%	2.76	9
5	Help managing money	2.38	12%	2.71	7
6	Dental care	2.5	23%	2.34	2
7	Emergency (immediate) shelter	2.63	16%	3.04	20
8	Family counseling	2.7	0%	2.85	12
9	Long-term, permanent housing	2.71	28%	2.25	1
10	Women's health care	2.77	4%	3.09	21
11	Welfare payments	2.77	0%	2.97	16
12	Education	2.81	4%	2.88	13
13	AIDS/HIV testing/counseling	2.85	4%	3.38	30
14	Job training	2.88	20%	2.88	14
15	Eye care	2.93	0%	2.65	5
16	Glasses	2.96	0%	2.67	6
17	SSI/SSD process	2.96	0%	3.02	19
18	Help with finding a job or getting employment	2.96	12%	3.00	17
19	Treatment for dual diagnosis	3	8%	3.01	18
20	Hepatitis C testing	3	0%	3.41	32
21	Help with medication	3.04	0%	3.18	24
22	Help with transportation	3.04	0%	2.82	11
23	Halfway house or transitional living facility	3.11	8%	2.76	8
24	Help getting needed documents or identification	3.12	0%	3.16	23
25	Services for emotional or psychiatric problems	3.15	8%	3.20	25
26	TB treatment	3.15	0%	3.45	33
27	Discharge upgrade	3.15	0%	2.90	15
28	TB testing	3.19	0%	3.58	36
29	Treatment for substance abuse	3.31	8%	3.30	28
30	Spiritual	3.37	0%	3.30	27
31	Personal hygiene (shower, haircut, etc.)	3.38	0%	3.21	26
32	Drop-in center or day program	3.38	0%	2.77	10
33	VA disability/pension	3.44	0%	3.33	29
34	Medical services	3.54	0%	3.55	34
35	Food	3.58	4%	3.56	35
36	Clothing	3.62	0%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.64	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.89	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.96	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.93	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.85	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.85	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.89	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.79	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.26	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.11	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.16	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.84	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.06	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.16	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.11	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Saginaw, MI - 655

VISN 11

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 4

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **4** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	75	0
Transitional Housing Beds	78	0
Permanent Housing Beds	50	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	The coalition is gathering data.
SSI/SSD process	Social Security has been requested to send a representative to the meeting. Thus, far Social Security office staffing has prohibited attendance at the meetings.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 13 Non-VA staff Participants: 92%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.08	64%	2.25	1
2	Eye care	2.36	0%	2.65	5
3	Dental care	2.45	0%	2.34	2
4	Glasses	2.45	0%	2.67	6
5	Halfway house or transitional living facility	2.46	18%	2.76	8
6	Treatment for dual diagnosis	2.54	9%	3.01	18
7	Drop-in center or day program	2.58	0%	2.77	10
8	Help with transportation	2.58	9%	2.82	11
9	Family counseling	2.62	0%	2.85	12
10	Child care	2.64	0%	2.39	3
11	Legal assistance	2.67	18%	2.61	4
12	Services for emotional or psychiatric problems	2.69	0%	3.20	25
13	Help with finding a job or getting employment	2.75	18%	3.00	17
14	Help managing money	2.83	0%	2.71	7
15	Education	2.83	0%	2.88	13
16	Women's health care	2.85	0%	3.09	21
17	Job training	2.85	9%	2.88	14
18	Welfare payments	2.91	9%	2.97	16
19	SSI/SSD process	2.92	18%	3.02	19
20	Detoxification from substances	3	0%	3.11	22
21	Discharge upgrade	3	0%	2.90	15
22	Guardianship (financial)	3.08	0%	2.76	9
23	AIDS/HIV testing/counseling	3.09	0%	3.38	30
24	TB testing	3.09	0%	3.58	36
25	VA disability/pension	3.18	0%	3.33	29
26	Hepatitis C testing	3.2	0%	3.41	32
27	Spiritual	3.2	0%	3.30	27
28	Treatment for substance abuse	3.23	9%	3.30	28
29	Help with medication	3.23	0%	3.18	24
30	TB treatment	3.27	0%	3.45	33
31	Help getting needed documents or identification	3.27	0%	3.16	23
32	Personal hygiene (shower, haircut, etc.)	3.31	0%	3.21	26
33	Medical services	3.31	0%	3.55	34
34	Emergency (immediate) shelter	3.38	9%	3.04	20
35	Food	3.46	0%	3.56	35
36	Clothing	3.54	0%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

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